HARISH RANA V/S UOI

(To be or not to be is the question…)

Citation: 2026 INSC 222

Forum: Supreme Court of India

Corum: J.B. Pardiwala, J. & K.V. Viswanathan, J.

INTRODUCTION:

On **11th March 2026**, the Supreme Court of India pronounced a landmark judgment, it was the first time that an Indian court permitted the withdrawal of *'Clinically Assisted Nutrition and Hydration' (CANH)* from a patient in a *Permanent Vegetative State (PVS*) with no '*Advance Medical Directive/' (AMD)*. The decision significantly develops the law on 'passive euthanasia' as laid down in *Common Cause v. Union of India* 2018[1] (hereinafter referred to as the 2018 guidelines), it also extends the 'best interest' principle to home-care patients, and calls for urgent parliamentary legislation on end-of-life care principle (EOL).

FACTS OF THE CASE:

In in August 2013, Harish Rana sustained severe 'diffuse axonal injury' when he fell from the fourth floor of his accommodation at age 20, while pursuing his B.Tech degree. Following which, he was taken to PGI Chandigarh and subsequently at AIIMS New Delhi for his treatment. Since 2013, he has been on a '*Percutaneous Endoscopic Gastrostomy'* (PEG) tube for nutrition, a tracheostomy, and a urinary catheter, continuously for over a period of 13 years. To determine the extend of his disability he was taken for certification twice (2014 and 2016), both the times it certified 100% disability and was diagnosed with Persistent Vegetative State (PVS) with complete sensorimotor dysfunction. Over the years, Harish has shown no signs of awareness, no purposeful movement and no response to pain, sound, or touch. Although he has sleep-wake cycles he still is unable to communicate, eat, or perform any self-care function. His neurological condition has remained static ever since the incident.

Looking at his condition, his parents filed for a writ petition in the year 2014, in the Delhi HC seeking to withdraw his life support, in this case the *CANH* treatment, but it was

[1] Common Cause v. Union of India, reported in (2018) 5 SCC 1

rejected on the grounds that, he was not being kept alive mechanically and hence, the condition *did not* require any judicial intervention. Further, the SC too disposed of the resulting SLP in November 2024 and directed 'home care' for the patient at government expense with liberty to approach the court again. However, upon deterioration of health and re-hospitalization in May 2025, his parents filed the present Miscellaneous Application (MA) seeking: *(i) constitution of medical boards per Common Cause Guidelines,* and (ii) a *declaration that CANH is 'medical treatment' permitting its withdrawal.* For these purposes, the Court constituted a Primary Medical Board (from Ghaziabad CMO) and a Secondary Medical Board (from AIIMS). Both boards unanimously found: irreversible PVS for 13 years, no prospect of recovery, and continuation of CANH as medically futile. The family of the patient essentially his parents, brother and sister unanimously and voluntarily requested withdrawal of the treatment, expressing that continued treatment only prolonged suffering.

ISSUES BEFORE THE COURT:

1. Whether the administration of CANH is to be regarded as 'medical treatment"?
2. What is the meaning, scope, and contours of the principle of "best interest of the patient" in determining whether medical treatment should be withdrawn or withheld?
3. Whether it is in the best interest of the applicant that his life be prolonged by continuation of medical treatment?
4. What are the further steps to be undertaken in the event that a decision to withdraw or withhold medical treatment is arrived at?

ARGUMENTS:

Plaintiff's Arguments (Harish Rana through his Parents):

It was argued that, CANH administered via PEG tube *is* a 'life-sustaining' medical intervention, widely recognized both medically as well as legally. Moreover, the 2018 guidelines themselves mention that feeding tubes constitute as life support. Subsequently, its withdrawal amounts to passive euthanasia, it's an act of omission and not active euthanasia. While observing if CANH is medical treatment, the High Court has erred by limiting the framework to only 'terminally ill' patients. The 2018 Guidelines, expressly cover PVS patients. The case of Aruna Shanbaug (2011) involved a PVS patient and the Common Cause Guidelines

were designed to cover exactly such cases. On the issue of applicability of the Common Cause Guidelines, it was said that the existing framework presupposes a hospital context. In the present matter, Harish is being cared for at home, therefore, there is no institution to trigger the medical board process, this, is creating an unaddressed procedural lacuna which leaves his family with no option but to approach the court of law.

While speaking on the procedural gap for home-care patients, it was argued that the question is not '*whether it is in his interest to die'*, but *whether it is in his best interest to have artificial life prolonged*? Given the 13 years of his PVS, no improvement, medical futility (as declared by doctors), and the family's considered decision, the continuation of medical treatment is not in his best interest. It was further stated that, the Common Cause Guidelines have not been translated into practice, which leaves the hospitals confused about obligations, consequently leading to harmful practices. The Court should rather direct states to create custodians for *Advanced Medical directives (AMDs),* mandatory hospital board mechanisms, and Chief Medical Officer (CMO) nominations for secondary medical boards.

Respondent's Argument (Union Of India):

As opposed to their adversarial nature, the UOI in the present matter unusually, *supported* the application. The ASG, on behalf of the Union, conceded that the withdrawal of 'futile life-sustaining treatment' is constitutionally permissible under Common Cause 2018 and *Article 21 of the Constitution*[2]. To explain the matters further, the UOI, agreed that *CANH* administered via PEG tube is medical treatment, and not mere basic care. The 2018 Guidelines, approved the *House of Lords'* reasoning in *Airedale NHS Trust v. Bland (1993)*[3]*, England* that the artificial feeding via tubes is medical treatment. By removing *CANH* does not cause death; but death follows from the underlying irreversible condition. This was affirmed by the medical boards and is consistent with the *Common Cause framework*. Further, it was presented that both the Medical boards (primary and secondary) and the learned ASG confirmed that the family's decision which they arrived at, after 13 years of exhaustive care is not only clear and categoric but also made without any coercion or external pressure. Lastly, the government prayed that 'palliative care' be arranged at home or at a hospital of the family's choice during

[2] INDIA CONST. art. 21.
[3] *Airdale NHS Trust v. Bland,* reported in (1993) All ER 821

and after withdrawal of CANH, to ensure dignity and comfort. Palliative care should accompany withdrawal:

JUDGEMENT:

After hearing the arguments from both sides, the highest Court allowed the Miscellaneous Application. J.B. Pardiwala, J. authored the main judgment while K.V. Viswanathan, J. wrote a concurring opinion. The bench said, CANH whether administered via nasogastric tube or PEG tube will constitute a 'medical treatment' and not basic care. The Court relied on the *House of Lords* in *Airedale (Bland)* and confirmed that the 2018 Guidelines have implicitly settled this position. Hence, withdrawal of CANH amounts an act of omission, falling squarely within permissible passive euthanasia under *Article 21.* Further, the SC held the High Court's dismissal as erroneous, they said the Common Cause Guidelines are not restricted to 'terminally ill' patients. A patient in PVS undergoing prolonged treatment for an incurable condition, even with no hope of recovery too satisfies the prerequisites for constitution of Medical Boards. The Court confirmed that both the AMD and no-AMD frameworks (as in the present matter) apply to PVS patients.

While arriving at this decision the Court conducted an extensive comparative survey (of the USA, the UK, Ireland, Italy, Australia, New Zealand, EU) and distilled the 'best-interest test' as fact-specific, holistic, and multi-factorial. They said the correct question is not *'should the treatment end?'* but *'does artificially prolonging treatment serve the patient's best interest?'* The court objectively found that even if there is a strong presumption in favour of life, but it is not absolute. Due to the prolonged treatment, which did nothing to improve the patient's condition, he has suffered enough, and that there is indignity in such condition. The expert opinion also hinted in the direction of 'futility' in prolonging the treatment. Moreover, the decision taken by the patient's kin is voluntary sans any pressure or coercion, and does not come from a place of feeling of abandonment rather tilts towards patient's welfare. The Court directed that the consequences under the 2018 Guidelines now operate permitting withdrawal of CANH. While recognising implementation challenges, the Court issued revised directions: (i) safeguarding checkpoints to protect doctors from legal liability; (ii) clarity on the role of next of kin; (iii) a framework for patients in home-care settings (not confined to hospitals); (iv) CMO nomination of a registered medical practitioner to secondary boards; (v) a

reconsideration period; and (vi) limited court intervention only in cases of disagreement between boards.

Lastly, the Court emphatically reiterated the urgent need for Parliament to enact a comprehensive statutory framework on passive euthanasia and end-of-life (EOL) care, noting that despite directions in Common Cause 2018, the *196th*[4] *and 241st Law Commission Reports*[5], and the draft *guidelines of 2024*[6], no legislation has been enacted. The Court directed the governments of States and Union Territories to implement the revised guidelines immediately and dispel confusion among medical practitioners.

ANALYSIS & KEY TAKEAWAYS

The present matter, is the first reported instance of an Indian court permitting withdrawal of CANH from a PVS patient without an AMD, it's a significant extension of the Common Cause framework from principle to practice. The Court has moved beyond a simplistic *'act vs. omission'* (active v/s passive) distinction. The physical act of removing a PEG tube, while a positive movement, is classified as passive euthanasia because it is the underlying condition not the physician's act, that causes death. This nuanced formulation provides much-needed clarity for medical professionals. The judgment consolidates global jurisprudence into an Indian doctrinal framework for the *best-interest principle* of the patient. It gives content to a previously abstract standard, making it workable for medical boards and courts alike.

The court correctly identified a critical procedural void and extended the Medical Board mechanisms to patients receiving long-term home care, a gap that had left Harish's family with no legal avenue for over a decade. Lastly, the also pointed out there is a need for legislative intervention as unless and until a legislation is not enacted each case of passive euthanasia will require the court's full attention, which it lacks abundantly.

[4] Law Commission of India, 196th Report "*Medical Treatment to Terminally Ill Patients (Protection of Patients and Medical Practitioners"* (2006).
[5] Law Commission of India, 241st Report *"'Passive Euthanasia – A Relook'"* (2012).
[6] Common Cause v. Union of India, reported in (2023) 14 SCC 131